Iowa Department of Human Services

2015 Provider Quality Management Self-Assessment

October 2015

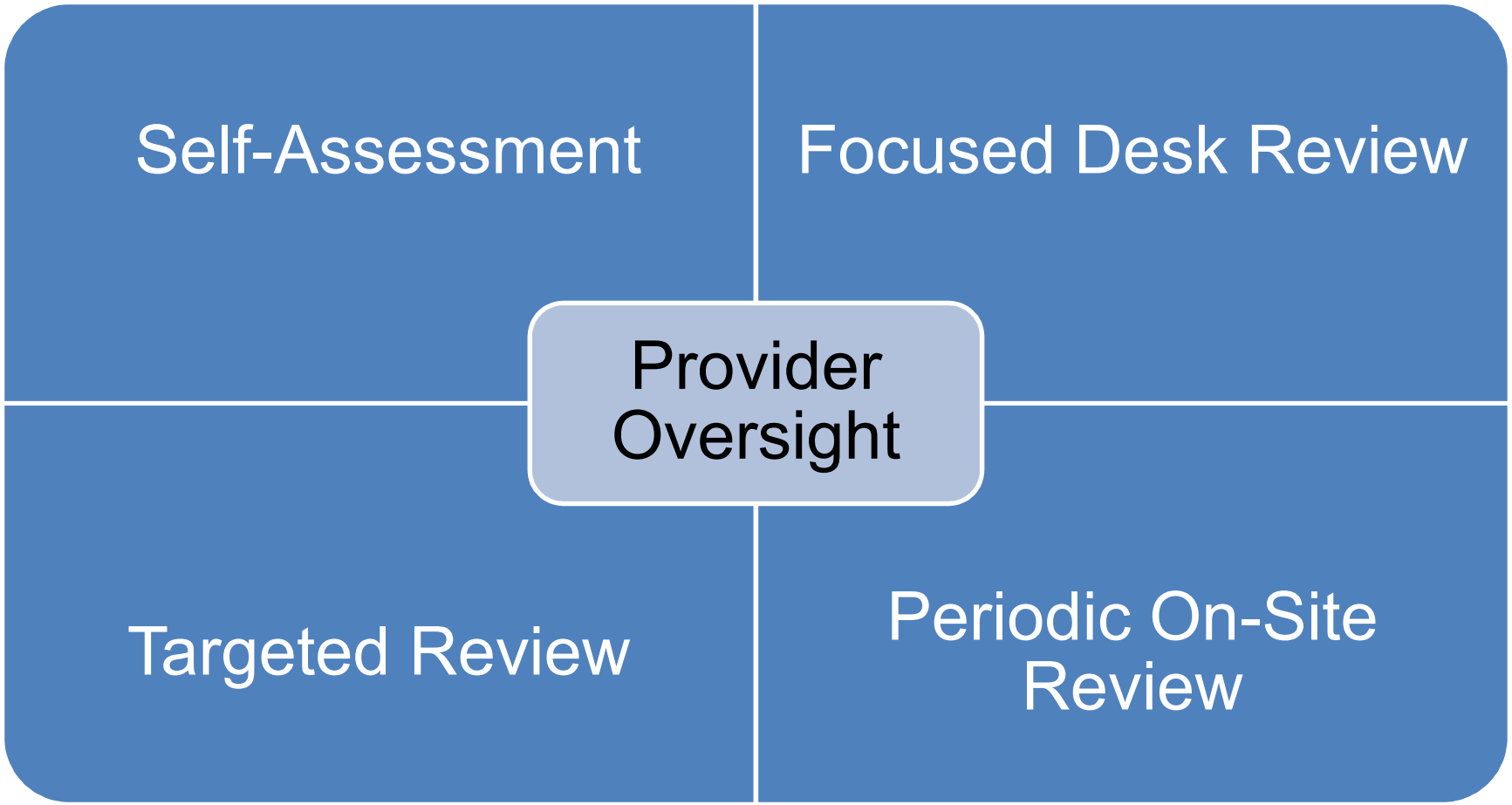
- The annual HCBS Self-Assessment process is currently underway with submission to occur by December 1, 2015 as instructed on the HCBS 2015 Provider Quality Management Self-Assessment Form 470-4547. The transition to IA Health Link managed care has not impacted the 2015 HCBS self-assessment process and therefore will not be discussed during this training.

- Any questions regarding managed care should be submitted to: MedicaidModernization@dhs.state.ia.us

Objectives

- Overview of the Home and Community Based Services (HCBS) Provider Quality Oversight process
- Familiarize providers with the 2015 Self-Assessment
- Identify and address frequently asked questions
- Provide resources for technical support

Four Methods of Provider Oversight



Focused Review

- The purpose is to verify the provision of quality service delivery.
- Providers are randomly selected to represent a variety of services, provider types and geographical areas or if issues are identified through other quality improvement activities.
- Focused Review Topics change annually.
- Outcome could result in commendations, recommendations, corrective actions or an on-site review.

Targeted Review

- Can be conducted as needed, either announced or unannounced. May consist of a desk review or may be completed on site.
- Initiated as a result of concerns arising from other quality oversight activities including other types of reviews, incident reports, complaints, member surveys, or referral from other units within IME.
- Outcome could result in commendations, recommendations, corrective actions, or sanctions

Periodic/Certification On-Site Reviews

- Considered a “full” review.
- Evaluates evidence to support quality service delivery by examining evidence of compliance with the Code of Federal Regulations (CFR), Iowa Code, and Iowa Administrative Code (IAC) standards.
- Periodic review occurs on 5-year cycle, certification reviews are combined with periodic review when possible.
- Outcome could result in commendations, recommendations, corrective actions or sanctions.

Self-Assessment

- Annual self-reporting tool on standards for service delivery for identified HCBS Medicaid providers.
  - Covered services are identified in Section B of the self-assessment

- Providers are expected to self-report on CFR, Iowa Code, and IAC requirements for specific services and implementation of best practice recommendations and develop corrective action plans as needed.

Self-Assessment (continued)

- Part of demonstrating your on-going internal quality improvement process.
- Opportunity to self-govern and assess outcome of future reviews.

Due Date

- By December 1, 2015
- **Incomplete self-assessments will not be accepted.**
- If any portion of the self-assessment is not completed as instructed, the provider will be notified and a completed self-assessment shall be resubmitted by the provider by December 1, 2015.
- **Failure to submit the required 2015 Quality Management Self-Assessment by December 1, 2015 will jeopardize your agency's Medicaid enrollment.**

New for 2015

- Formatting and streamlining
- Additional data collection in Section C regarding HCBS integrated settings
- Continued from 2014
  - Person-Centered Service Plan 42 CFR 441.725.
  - Centers for Medicare and Medicaid Services (CMS) Final Rule on HCBS settings
    - If your agency has not fully implemented changes to demonstrate compliance, please include corrective action plans as required.

The 2015 Self-Assessment

- http://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment

- Save form to your computer
- Complete electronically
- Read instructions carefully

Home- and Community-Based Services (HCBS)
2015 Provider Quality Management Self-Assessment

This form is required for entities enrolled to provide services in Section B under the following waivers/programs:

- Health and Disability Waiver
- AIDS/HIV Waiver
- Elderly Waiver
- Children's Mental Health Waiver (CMH)
- Intellectual Disability Waiver (ID)
- Brain Injury Waiver (BI)
- Physical Disability Waiver (PD)
- HCBS Habilitation Services (Hab)

This form is set up as a fillable pdf and is to be completed and submitted as directed below. Each provider is required to submit one, six-section self-assessment by **December 1, 2015**. **Incomplete self-assessments will not be accepted**. For assistance with the template, visit the Provider Quality Management Self-Assessment[1] webpage to download a help sheet.

The completed *2015 Provider Quality Management Self-Assessment* should be returned to:

Attention: Provider Quality Management Self-Assessment
Iowa Medicaid Enterprise
HCBS Quality Oversight
PO Box 36330
Des Moines, IA 50315
Fax: 515-725-3536 (preferred)

Section A. Identify the agency submitting this form.

Section B. Identify the programs and services your agency is enrolled to provide. If you are uncertain which services you are enrolled for, contact Iowa Medicaid Enterprise (IME) Provider Services at 800-338-7909, option 2 or imeproviderservices@dhs.state.ia.us.

Section C-1. Identify each location where this agency has offices. For agencies with only one office, the address in Section C should identify that one location.

Section C-2. Identify each **new** provider-owned or provider-controlled location in which HCBS began after December 1, 2014. For agencies with only one site where service is provided, the site address in Section C-2 should identify that one location.

Section C-3. Identify all service locations in which HCBS are provided in a publicly- or privately-owned facility located on the grounds of, or immediately adjacent to, a public institution or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.

Section D. Select the response option from the "Response Option" column that indicates the most accurate response for each item. If required areas are incomplete, the self-assessment will be returned to the agency and must be resubmitted.

[1] https://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment

Section A. Agency Identification

Please identify your agency by providing the following information. Please type using the text entry fields below.

Employer ID number (EIN) (9-digits):					
Agency name (as registered to EIN indicated above):					
Administrator/CEO:			Title:		
Mailing address:			Agency address:		
City:	State:	Zip:	City:	State:	Zip:
County:			County:		
Name of person responsible for agency quality improvement activities:			Phone number: Ext:		
Title of person responsible for agency quality improvement activities:			Fax number:		
Quality coordinator's email address:			Administrator's email address:		
Agency website address:					

Section A – Provider Identification (continued)

- Demographic Information
- EIN = employer ID# or taxpayer ID#
- Legal name, if different from name you are doing business as(DBA)
- Correct email addresses
- If you have had a change in legal name or address, complete form 470-4608 on http://dhs.iowa.gov/ime/providers/forms

Section B. Service Enrollment

Indicate *each* of the programs and corresponding services your agency is **enrolled** to provide (regardless of whether or not these services are currently being provided). If your agency is not enrolled for any of the services in this section, you are not required to submit the *2015 Provider Quality Management Self-Assessment*. If you are uncertain as to the services your agency is enrolled for, please contact the IME Provider Services as explained on page one.

Program	☐ AIDS/HIV Waiver	☐ BI Waiver	☐ CMH Waiver
Services	☐ Adult day services ☐ Agency Consumer-Directed Attendant Care (CDAC) ☐ Counseling ☐ Respite	☐ Adult day services ☐ Behavior programming ☐ Agency Consumer-Directed Attendant Care (CDAC) ☐ Family counseling and training ☐ Interim Medical Monitoring and Treatment (IMMT) ☐ Prevocational services ☐ Respite ☐ Supported Community Living (SCL) ☐ Supported Employment (SE)	☐ Family and community support services ☐ In-home family therapy ☐ Respite

Section B – Service Enrollment (continued)

- Select ALL services you are enrolled for.
- You may be enrolled for additional HCBS services not listed in Section B. These services are not part of the self-assessment or HCBS quality oversight process.
- Self-Assessment answers will be based on policies and procedures for the services indicated in Section B.

Section C-1. Office Locations

INSTRUCTIONS Identify each location from which your agency provides oversight of HCBS. Include additional copies of this page as needed.

■ Location # 1

NPI number(s) (10-digits):					
Agency name (Name doing business as):					
Contact person:			Phone number:		Fax number:
Title of contact person:			Email address:		
Mailing address:			Agency address:		
City:	State:	Zip:	City:	State:	Zip:
Office Hours:	Monday:_____ Tuesday:_____ Wednesday:_____ Thursday:_____ Friday:_____ Saturday:_____ Sunday:_____				

■ Location # ___

NPI number(s) (10-digits):					
Agency name (Name doing business as):					
Contact person:			Phone number:		Fax number:
Title of contact person:			Email address:		
Mailing address:			Agency address:		
City:	State:	Zip:	City:	State:	Zip:
Office Hours:	Monday:_____ Tuesday:_____ Wednesday:_____ Thursday:_____ Friday:_____ Saturday:_____ Sunday:_____				

Section C-1 - Office Locations (continued)

- Include all agency office locations, including satellite offices.
  - List all NPIs related to each office location.
- Can print additional pages as necessary for all office locations.
- Do not include 24-hour residential sites as a location unless an agency office is located at that site.

Section C-2 – Site Locations

- **Only submit site locations new in 2015, or sites that were not otherwise reported in 2014.**
- Part of Iowa's transition plan submitted to CMS to gather information on current HCBS service locations
- A setting is considered provider-owned or controlled when it is a specific physical place that is owned, co-owned, and/or operated by a provider of HCBS.
- Applies to all services identified in Section B, **except** Respite.

Section C-2 – Site Locations Examples:

Provider owned/controlled site may be:

-buildings owned or leased by the provider agency

-have staff present for 24-hour care

-nursing facility or intermediate care facility (ICF)

Member owned/controlled site may be:

-owned by member

-leased by member from someone not affiliated with the provider agency

-owned by member's legal guardian

Section C-2. New Site Locations

INSTRUCTIONS Identify new provider-owned or provider-controlled locations in which HCBS began after December 1, 2014. Provider-owned and provider-controlled categories are clarified in the HCBS Settings Transition Exploratory Questions located on the DHS website [3]. Include additional copies of this page as needed.

■ **Site #** ___

NPI number (10-digits):		Site name:	
Agency name (Name doing business as):			
Contact person:		Phone number:	Fax number:
Title of contact person:		Email address:	
Site address:		☐ Residential (home/apartment) ☐ Non-residential (vocational/day program)	
City:	State: Zip:	For residential sites with five or more members, is the site licensed by the Department of Inspections and Appeals or otherwise approved by the Department of Human Services?	
Type of residence (house, apartment, etc.):			
Total number of members living at this site:		☐ Yes ☐ No	

Section C-3– All Service Locations New in 2015

- Identify all HCBS service locations :
  - Provided in a publicly or privately-owned facility that provides inpatient treatment;
  - On the grounds of, or immediately adjacent to, a public institution
  - Has the effect of isolating individuals receiving HCBS from the broader community of individuals not receiving HCBS.
- Do not include 24-hour residential sites as a location unless an agency office is located at that site.

Section C-3. All Service Locations

INSTRUCTIONS Identify all service locations in which HCBS are provided in a publicly- or privately-owned facility that provide inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.

■ **Site #** ___

NPI number (10-digits):		Site name:	
Agency name (Name doing business as):			
Contact person:		Phone number:	Fax number:
Title of contact person:		Email address:	
Site address:		☐ Residential (home/apartment) ☐ Non-residential (vocational/day program)	
City:	State: Zip:	For residential sites with five or more members, is the site licensed by the Department of Inspections and Appeals or otherwise approved by the Department of Human Services?	
Type of residence (house, apartment, etc.):			
Total number of members living at this site:		☐ Yes ☐ No	

■ **Site #** ___

NPI number (10-digits):		Site name:	
Agency name (Name doing business as):			
Contact person:		Phone number:	Fax number:
Title of contact person:		Email address:	
Site address:		☐ Residential (home/apartment) ☐ Non-residential (vocational/day program)	

Section D – Iowa Administrative Code Standards

I. **Providers are required to establish and maintain fiscal accountability** IAC Chapters 78 and 79	
***At a minimum*, all providers will maintain evidence of:**	**Response Options:**
1. The current rate setting system (*for example*, D-4s, fee schedules, County Rate Information System report)	☐ Yes ☐ No
2. Documentation to support planning and tracking the use of member support dollars that are incorporated into the rate for SCL, RBSCL, home-based habilitation, and family and community support services	☐ Yes ☐ No ☐ N/A
3. The maintenance of fiscal and clinical records for a minimum of five years	☐ Yes ☐ No
If indicating "No," describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):	
If indicating "NA," you must describe why the standard(s) are not applicable to your agency:	

Section D – Iowa Administrative Code Standards (continued)

- You must select a response for each standard. Any self-assessments with unanswered standards or comments will be returned and considered not complete.
  - If indicating “Yes”, it means you have a policy and/or evidence in place as required. It is not necessary to explain your response.
  - If indicating “No”, you must describe a corrective action plan (CAP) to meet the standards
  - If indicating “NA”, you must describe why the standard(s) are not applicable to your facility.

Section D – III. Requirement B. HCBS settings required for all providers

- Applies to providers of all HCBS services covered by the self-assessment
  - A – F applies to all HCBS services
  - G - K applies to HCBS services in provider-owned, provider-controlled settings
- Compliance may be evidenced in the provider or case management service plan, or other documents.

Requirement B. HCBS settings required for all providers ***At a minimum*, there will be evidence of:**	**Response Options:**
1. **All providers** at a minimum, community integration will be supported by:	
a. The setting is integrated in, and facilitates the individual's full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, like individuals without disabilities	☐ Yes ☐ No
b. The setting is selected by the individual among available alternatives and identified in the person-centered service plan	☐ Yes ☐ No
c. An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected	☐ Yes ☐ No
d. Individual initiative, autonomy, and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented	☐ Yes ☐ No
e. Individual choice regarding services and supports, and who provides them, is facilitated	☐ Yes ☐ No
f. All rights restrictions must be time limited, contain member's informed consent, supported by a specific assessed need and documented in the person-centered service plan	☐ Yes ☐ No
g. In provider-owned or provider-controlled setting, each individual has privacy in their sleeping or living unit	☐ Yes ☐ No ☐ N/A
h. In a provider owned or provider controlled setting, individuals sharing units have a choice of roommates in that setting	☐ Yes ☐ No ☐ N/A
i. In a provider-owned or provider-controlled setting, individuals have the freedom and support to control their own schedules and activities, and have access to food at any time	☐ Yes ☐ No ☐ N/A
j. In a provider-owned or provider-controlled setting, individuals are able to have visitors of their choosing at any time	☐ Yes ☐ No ☐ N/A
k. In provider-owned or provider-controlled setting, the setting is physically accessible to the individual	☐ Yes ☐ No ☐ N/A
l. Provider-owned or provider-controlled home is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord/tenant laws of the state, county, city, or other designated entity	☐ Yes ☐ No ☐ N/A
m. Provider-owned or provider-controlled home has entrance doors lockable by the individual, with only appropriate staff having keys to doors	☐ Yes ☐ No ☐ N/A
n. In a provider-owned or provider-controlled home individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	☐ Yes ☐ No ☐ N/A

Section D – III. Requirement C. Person centered planning

- Condensed in 2015 to remove duplicate standards
- Applies to all HCBS providers
- Evidenced by current, complete case management service plans or the individual provider service plan

Section D – III. Requirement C. Person centered planning (cont.)

Requirement C. Person centered planning for all providers ***At a minimum*, there will be evidence of:**	**Response Options:**		
All providers at a minimum, person centered planning will be supported by:			
a. Provider participates in interdisciplinary team meetings	☐ Yes	☐ No	☐ N/A
b. Provider member file contains a copy of the written person centered plan	☐ Yes	☐ No	☐ N/A
c. Provider's plan is consistent with the case manager's person centered plan	☐ Yes	☐ No	☐ N/A
d. The provider's service plan includes interventions and supports needed to meet individual goals with incremental action steps, as appropriate	☐ Yes	☐ No	☐ N/A
e. The provider's plan reflects desired individual outcomes	☐ Yes	☐ No	☐ N/A
f. The provider's service plan includes documentation of any rights restrictions, why there is a need for the restriction and a plan to restore those rights or a reason why a plan is not necessary or appropriate	☐ Yes	☐ No	☐ N/A
If indicating "No," describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):			
If indicating "NA." you must describe why the standard(s) are not applicable to your facility:			

Section D – III. Requirement I Contracts with members

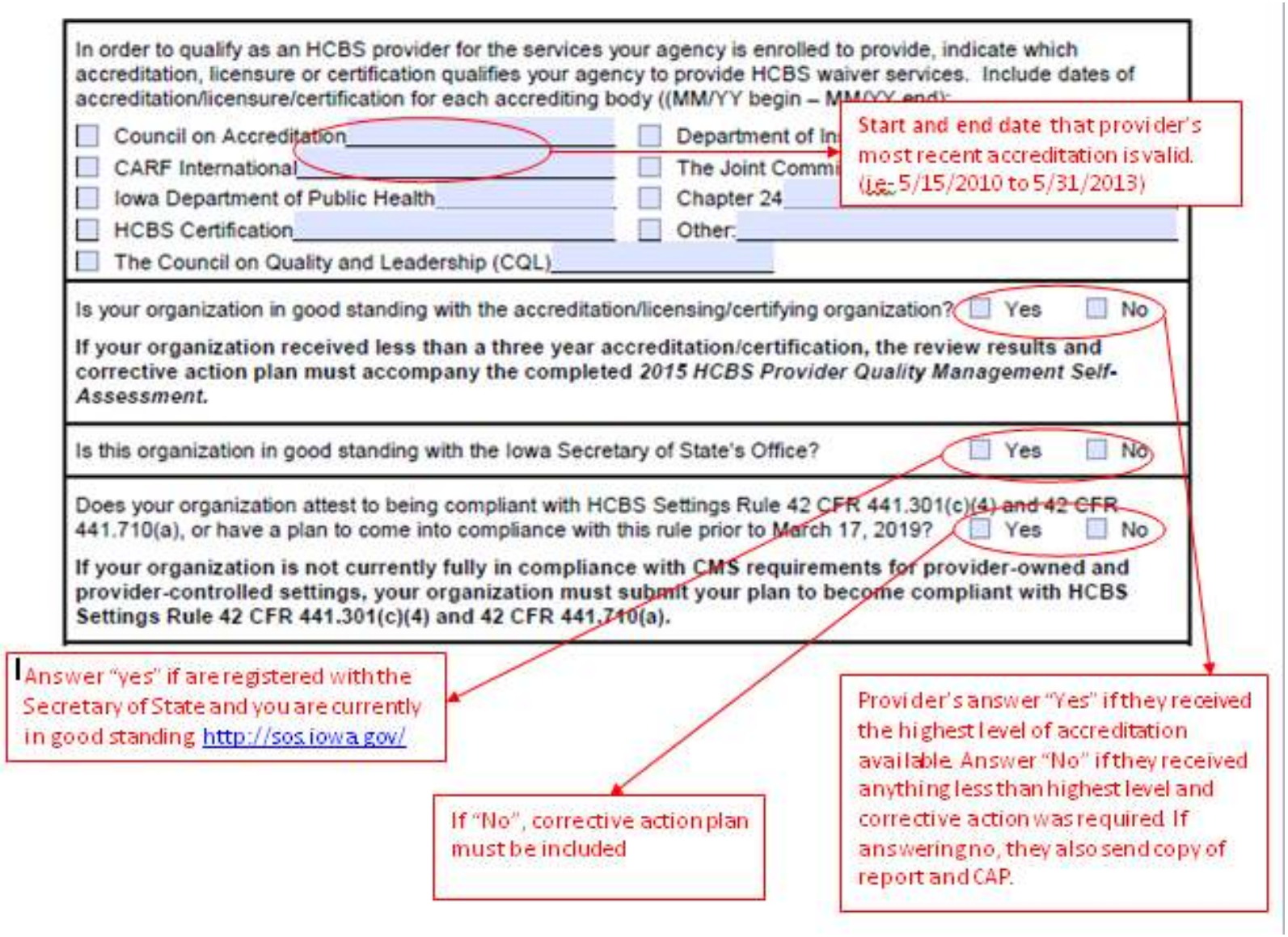
- According to Iowa Administrative Code, only required per Chapter 77.37(3) for ID Supported Employment and SCL providers (excludes RBSCL).

Requirement I. Contracts with members ***At a minimum*, the agency shall have written procedures which provide for the establishment of an agreement between the member and the provider and evidence will be supplied that:**	**Response Options:**
1. The agreement shall define the responsibilities of the provider and the member, the rights of the member, the services to be provided to the member by the provider, all room and board and co-pay fees to be charged to the member and the sources of payment	☐ Yes ☐ No ☐ N/A
2. Contracts shall be reviewed at least annually	☐ Yes ☐ No ☐ N/A
If indicating "No," describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):	
If indicating "NA," you must describe why the standard(s) are not applicable to your agency:	

Section D - IV. Requirement A. Quality Improvement Plan

- Reflects QIP development and implementation according to current Iowa Administrative Code requirements.
  - Written QI Plan
  - Discovery, Remediation, and Improvement activities
- Allows providers to self-identify and correct areas of need.
- Allows flexibility in data collected and acceptable thresholds

Section E – Guarantee of Accuracy



Section E – Guarantee of Accuracy (continued)

- Accreditation/Licensing/Certification needed to provide enrolled HCBS services
  - Identify the organization(s) from the list provided
  - Include start and end dates of accreditation/licensure/certification
  - Accreditation review results and corrective action plan must be included if less than a 3 year accreditation

Section E – Guarantee of Accuracy (continued)

- Signatures ensure the information is accurate, complete, and verifiable
  - May be signed digitally
  - Self-Assessments without signatures will be returned
  - Factor in time to obtain signatures
  - Indicate if your agency does not have a board of directors

Iowa Department of Human Services

2015 Provider Quality Management Self-Assessment

Section F. Direct Support Professional Workforce Data Collection

Agency Name_____

NPI Provider Number(s)_____
(Complete only one form and list all NPI Numbers)

Instructions
For the purposes of these questions, a direct support professional is an individual who provides supportive services and care to people who are elderly, experiencing illnesses, or disabilities. This definition *excludes* individuals working as nurses, social workers, counselors, and case managers.

Individuals providing the following waiver services should be considered direct support professional workers:

- Adult Day Services
- Behavioral Programming
- CCO
- CDAC
- Family and Community Support Services
- Home Health
- Homemaker
- Interim Medical Monitoring and Treatment
- Prevocational Services
- Respite
- Residential SCL
- SCL
- Supported Employment

1. Please list your organization's total number of full-time and part-time employees (including contract employees).

   _____ Total Number of Full-time and Part-time Employees

   Of this total, please list the number of full-time and part-time employees providing direct support services according to the definition provided above. Please include supervisors and coordinators who provide direct support services.

   _____ Number of Full-time Direct Care Workers (including contract employees)

   _____ Number of Part-time Direct Care Workers (including contract employees)

2. The U.S. Department of Labor utilizes the following three titles and definitions to gather information on the direct support professional workforce.

Please list the number of individuals you employ in the following three categories. Choose the category that best reflects services provided. Individuals do not need to be certified as a home health aide or nurse aide to be included in those categories. An individual cannot be counted in more than one category.

Personal and Home Care Aides

Often called direct support professionals, these workers provide support services such as implementing a behavior plan, teaching self-care skills and providing employment support, as well as providing a range of other personal assistance services. They provide support to people in their homes, residential facilities, or in day programs, and are supervised by a nurse, social worker, or other non-medical manager.

_____ Number of Personal and Home Care Aides (including contract employees)

Home Health Aides

Home health aides typically work for home health or hospice agencies and work under the direct supervision of a medical professional. These aides provide support to people in their homes, residential facilities, or in day programs. They help with light housekeeping, shopping, cooking, bathing, dressing, and grooming, and may provide some basic health-related services such as checking pulse rate, temperature, and respiration rate.

_____ Number of Home Health Aides (including contract employees)

Nursing Aides

Most Nursing Aides have received specific training for the job and some have received their certification as a Certified Nursing Assistant (CNA) in Iowa. According to the Department of Labor, Nursing Aides provide hands-on care under the supervision of nursing and medical staff in hospitals and nursing care facilities, although they do work in home and community based settings as well. Nursing Aides often help individuals eat, dress, and bathe, and may take temperature, pulse rate, respiration, or blood pressure, as well as observing and recording individuals' physical, mental, and emotional conditions.

_____ Number of Nursing Aides (including contract employees)

Timeliness

- Due by December 1, 2015
- Implementation of corrective action to address current CFR, Iowa Code, and IAC standards must be completed within 30 days of the date in Section E.
- For any areas relating to HCBS settings per 42 CFR 441.301(c)(4) and 42 CFR 441.710, corrective action must identify how providers will come into compliance on or before March 17, 2019.
- **Failure to submit the required 2015 Quality Management Self-Assessment will jeopardize your agency's Medicaid enrollment.**

Submission

- Self-Assessment will be submitted as one complete document
- Fax or Mail only
  - Fax preferred
- Include supporting documentation from accreditation, only if needed (See Section E – Guarantee of Accuracy)

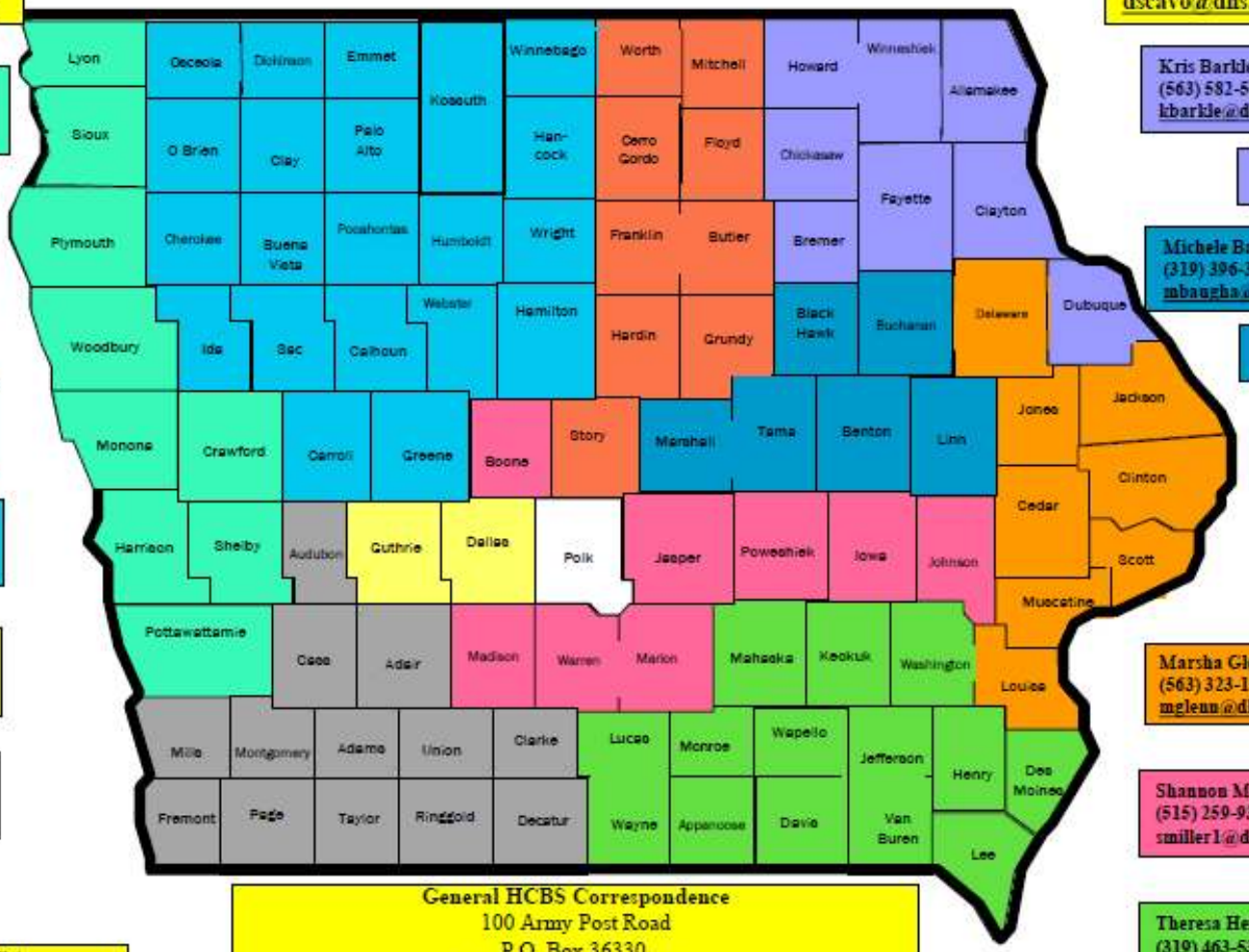
What to expect following submission

- Providers will receive confirmation of receipt by IME
- Incomplete submission
  - If areas are incomplete or corrective action was not identified, the provider will be notified and the self-assessment must be resubmitted.
  - The December 1, 2015 due date still remains.

HCBS Support

- Where to find more information/support
  - Website http://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment
    - Self-Assessment Help Sheet
    - Frequently Asked Questions (FAQs)
    - Self-Assessment Training Slides
    - Link to regional specialist map
  - Informational Letter No.1556

HCBS SPECIALIST OVERSIGHT REGIONS



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Stephanie Jones (515)-256-4654
sjones@dhs.state.ia.us

General HCBS Correspondence
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Des Moines, Iowa 50315
Fax: 515-725-3536
waiverslot@dhs.state.ia.us : Waiver wait list/slot questions
hcbsir@dhs.state.ia.us : Complaints and Incident report follow-up
hcbswaiver@dhs.state.ia.us : General HCBS questions

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Additional Resources

- Centers For Medicare and Medicaid Services
  http://www.cms.gov/

- Iowa Code and Iowa Administrative Code (IAC):
  http://search.legis.state.ia.us/nxt/gateway.dll/ic?f=templates&fn=default.htm

- HCBS Settings Transition
  http://dhs.iowa.gov/ime/about/initiatives/HCBS

Additional Resources (cont.)

- Informational Letter sign-up on IMPA homepage: https://secureapp.dhs.state.ia.us/impa

- Archived Informational Letters http://dhs.iowa.gov/ime/providers/rulesandpolicies/bulletins

- Provider Services:

  http://dhs.iowa.gov/ime/providers

  imeproviderservices@dhs.state.ia.us

  1-800-338-7909 (toll free) or 515-256-4609 (Des Moines)

  Select Option 4

- Send questions to:

hcbsqi@dhs.state.ia.us

Subject: 2015 Self-Assessment